STUDENT FORMS

Welcome to Riverside Community Hospital
PARKING

- Please park in the employee parking lot, located behind the hospital at 4550 Brockton Ave., corner of Tequesquite Ave. Assigned levels are 3, 4, & 5. There is a pathway that will lead you to the main entrance of the hospital (see the red arrows below).

- Once inside the Visitor Parking garage, take the stairs or elevators to the 4th level and continue towards the main entrance of the hospital. To find the GME Department: from the main lobby, continue past the elevators towards Human Resources. Follow the arrows pointing towards Residency Program Offices.

*Please DO NOT* park in the DeAnza Center lot or in any patient/visitor designated parking areas as your vehicle may be booted or towed.
Agency, Vendor, Student
Verification and Attestation

Print Name: _______________________________ Date: __________________

School/Organization: ______________________________________________________

I hereby acknowledge receipt of orientation material specific to Riverside Community Hospital. I attest by my signature below that I have reviewed and understand the content, and agree to abide by all policies, procedures, rules and regulations of Riverside Community Hospital. I have been given an opportunity to ask questions and clarify any information. If at a later time I have questions, I understand that I can direct them to my supervisor, charge nurse, manager, director, the education department, or human resources. I understand that all of the departments at Riverside Community Hospital are here to support me in providing outstanding patient care and other services to our patients and their families.

_____________________________ __________________________
Signature Date
Vendor Confidentiality and Security Agreement

Note: this form to be used for individual vendor representatives.

I understand that the HCA affiliated facility or business entity (the “Company”) for which I provide services, manages health information as part of its mission to treat patients. Further, I understand that the Company has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, credentialing, intellectual property, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, “Confidential Information”).

In the course of my assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Company systems.

General Rules
1. I will act in accordance with the Company’s Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of privileges, and/or termination of authorization to work within the Company facility or with Company data.

Protecting Confidential Information
4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.
5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Company business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
6. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Company Information Security Standards and Company record retention policy (provided upon request).
7. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
8. I will not transmit Confidential Information outside the Company network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Company using email or other electronic communication methods, I will ensure that the Information is encrypted according to Company Information Security Standards (provided upon request).

Following Appropriate Access
9. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
10. I will not attempt to bypass Company security controls.
11. I will only access software systems to review Company information when I have a business need to know, as well as any necessary consent. By accessing Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.

Using Mobile Devices, Portable Devices and Removable Media

12. I will not copy or store Confidential Information on mobile devices, portable devices, or removable media such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job assignment. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Company Information Security Standards (provided upon request).

13. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes Company data (e.g., Company email) may contain Confidential Information and as a result, must be protected as required by Company Information Security Standards (provided upon request).

Doing My Part – Personal Security

14. I understand that I will be assigned a unique identifier (e.g., 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data.

15. I will:
   a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
   b. Use only approved licensed software.
   c. Use a device with virus protection software.

16. I will never:
   a. Disclose passwords, PINs, or access codes.
   b. Allow another individual to use my digital identity (e.g., 3-4 User ID) to access, modify, or delete data and/or use a computer system.
   c. Use tools or techniques to break/exploit security measures.
   d. Connect unauthorized systems or devices to the Company network.

17. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.

18. I will immediately notify the Company facility’s Facility Information Security Official (FISO), Director of Information Security Operations (DISO), or Facility or Corporate Client Support Services (CSS) help desk if:
   a. my password has been seen, disclosed, or otherwise compromised;
   b. media with Confidential Information stored on it has been lost or stolen;
   c. I suspect a virus infection on any system;
   d. I am aware of any activity that violates this agreement, privacy and security policies; or
   e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Company systems.

Upon Termination

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.

20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.

21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Company.
By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

<table>
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<th>Vendor signature</th>
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<tbody>
<tr>
<td>Vendor printed name</td>
<td></td>
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<tr>
<td>Signature of Vendor Manager</td>
<td>Date</td>
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<tr>
<td>Vendor Manager Printed name</td>
<td>Vendor Manager (Phone #)</td>
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</table>
Mandatory Child & Dependent Adult Abuse Reporting Statement

**Mandatory Child Abuse Reporting - California Penal Code Section 11166.5** requires Riverside Community Hospital to provide this statement: any mandated reporter as specified in Section 11165.7, hired on and after January 1, 1985, prior to commencing his or her employment, and as a prerequisite to that employment, shall sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions. The statement shall inform the employee that he or she is a mandated reporter and inform the employee of his or her reporting obligations under Section 11166 and of his or her confidentiality rights under subdivision (d) of Section 11167. The employer shall provide a copy of Sections 11165.7, 11166, and 11167 to the employee.

**Mandatory Dependent Adult Abuse - California Welfare and Institutions Code Section 15659** requires Riverside Community Hospital to provide any person who enters into employment on or after January 1, 1995, as a care custodian, clergy member, health practitioner, or with an adult protective services agency or a local law enforcement agency, prior to commencing his or her employment and as a prerequisite to that employment, shall sign a statement on a form that shall be provided by the prospective employer, to the effect that he or she has knowledge of Section 15630 and will comply with its provisions. The employer shall provide a copy of Section 15630 to the employee. The statement shall inform the employee that he or she is a mandated reporter and inform the employee of his or her reporting obligations under Section 15630. The signed statement shall be retained by the Riverside Community Hospital.

I CERTIFY THAT I HAVE RECEIVED A COPY OF CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 15659 AND 15630 IN MY EMPLOYEE ORIENTATION HANDBOOK. I UNDERSTAND AND WILL COMPLY WITH MY OBLIGATIONS UNDER THE DEPENDANT ADULT ABUSE REPORTING LAW.

AND

I CERTIFY THAT I HAVE RECEIVED A COPY OF CALIFORNIA PENAL CODE SECTION 11166.5, 11165.7, 11166, 11167 IN MY EMPLOYEE ORIENTATION HANDBOOK. I UNDERSTAND AND WILL COMPLY WITH MY OBLIGATIONS UNDER THE CHILD ABUSE REPORTING LAW.

____________________________________  __________________
Signature                      Date

____________________________________
Name
EXHIBIT A
STATEMENT OF RESPONSIBILITY

1. For and in consideration of the benefit provided the undersigned in the form of clinical rotation experience in evaluation and treatment of patients Riverside Community Hospital ("Hospital"), the undersigned and his/her heirs, successors and/or assignee do hereby covenant and agree to assume all risks and be solely responsible for any injury or loss sustained by the undersigned while participating in the Program operated by ____________________ ("School") at Hospital unless such injury or loss arises solely out of Hospital’s gross negligence or willful misconduct.

2. I agree to obtain a physical examination within one year prior to entering into the Training Experience at Hospital and to provide proof of the following:

   (a.) Negative result to a 10-panel drug screen (Including: Marijuana, Cocaine, Amphetamines, Opiates, PCP, Barbiturates, Benzodiazepines) consistent with testing done on Hospital employees but no less than a 10-panel drug screen.

   (b.) Tuberculosis: proof of non-infectivity with pulmonary tuberculosis annually by completing either (i), (ii), (iii) or (iiii):

      (i) Two-step TB skin test (TST) for students with no history or a positive TST who have not been tested in the last 12 months;
      (ii) One step TST test for students with proof of a negative TST in the last 12 months;
      (iii) Negative chest radiograph for students with proof of past positive TST;
      (iv) Negative blood test results.

   (c.) Rubella: documented receipt of one vaccination after 1st birthday, born before 1957, serological evidence of immunity. This is Mandatory.

   (d.) Chicken pox: documented receipt of vaccination, serological evidence of immunity or statement of refusal.

   (e.) Hepatitis B: documented vaccine series of three doses, serological evidence of immunity or statement of refusal.

   (f.) Tetanus, Diphtheria, and Pertussis (Tdap): documented inoculation within ten (10) years or statement of refusal.

   (g.) Seasonal Flu Immunization: documented inoculation or statement of refusal; and

   (h.) Certification from a licensed physician that I am free of any casually transmitted communicable disease in a contagious stage.

3. I agree to obtain, at my own cost, if my school has not completed, a criminal background check to include as a minimum:

   (a.) Social Security number verification
   (b.) Seven year multi-county or statewide Felony and related Misdemeanor search
   (c.) Civil and criminal public filings for the State of California
   (d.) Education verification (highest degree received)
   (e.) Professional licensure verification – Professional disciplinary action check
   (f.) Certification and designation check

4. I agree to provide the Hospital with the Background Information for Hospital's review prior to my acceptance by Hospital.

5. I agree to conform to all applicable Hospital policies, procedures, and regulations, and such other requirements and restrictions as may be mutually specified and agreed upon by the Hospital Designated Representative and School.

6. I understand and agree that I am responsible for my own support, maintenance and living quarters while participating in the Training Experience and that I am responsible for my own transportation to and from the Hospital.
7. I understand and agree that I am responsible for my own medical care needs. I understand that Hospital will provide access to emergency medical services should the need arise while I am participating in the Training Experience. However, I understand and agree that I am fully responsible for all costs related to general medical or emergency care, and that Hospital shall assume no cost or financial liability for providing such care.

8. I acknowledge that I have received training in blood and body fluid standard precautions consistent with the guidelines published by the U.S. Centers for Disease Control and Prevention. Documentation of such training shall be provided prior to beginning my Internship Program.

9. I acknowledge that I will receive academic credit for the Training Experience provided at Hospital and that I will not be considered an employee of Hospital or School, nor shall I receive compensation from either the Hospital or the School. I further acknowledge that I am neither eligible for nor entitled to workers’ compensation benefits under Hospital’s or School’s coverage based upon my participation in Program. I further acknowledge that I will not be provided any benefit plans, health insurance coverage, or medical care based upon my participation in this Program.

10. I understand that Hospital may suspend my right to participate in the Training Experience if, in its sole judgment and discretion, my conduct or attitude threatens the health, safety or welfare of any patients, invitees, or employees at Hospital or the confidentiality of any information relating to such persons, either as individuals or collectively. I further understand that this action shall be taken by Hospital only on a temporary basis until after consultation with School. The consultation shall include an attempt to resolve the suspension, but the final decision regarding my continued participation in the Program at Hospital is vested in Hospital.

11. I agree to comply with discrimination regulations and shall not discriminate against any person because of race, color, religion, sex, marital status, sexual orientation, national origin, age, physical handicap, or medical condition as provided by law.

12. I further understand that Hospital has the right to suspend use of their facilities in connection with this Training Experience should their facilities be partially damaged or destroyed and such damage is sufficient to render the facilities untenable or unstable for their purpose while not entirely or substantially destroyed.

13. I recognize that medical records, patient care information, personnel information, reports to regulatory agencies, conversations between or among any healthcare professionals are considered privileged and should be treated with utmost confidentiality. I understand that use, disclosure or duplication of any patient’s medical record is not permissible. I further understand that if it is determined that a breach in confidentiality has occurred as a result of my actions, I can be held liable for damages that result from such a breach.

14. I will wear the designated uniform of the school with badge identification at all times while participating in the Training Experience and identify myself as a student to the patients and staff I encounter. I will not wear open toe shoes or artificial nails in the clinical area.

I have read the foregoing; I understand and agree to the terms therein. I recognize that as consideration for agreeing to said terms Hospital will permit me to participate in the Training Experience at Hospital.

______________________________________
Signature of Participant

Print Name: ____________________________________________

Date: ___________________________________________________
**EXHIBIT B**

**PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY STATEMENT**

- Protected Health Information (PHI) includes patient information based on examination, test results, diagnoses, response to treatment, observation, or conversation with the patient. This information is protected and the patient has a right to the confidentiality of his or her patient care information whether this information is in written, electronic, or verbal format. PHI is individually-identifiable information that includes, but is not limited to, patient’s name, account number, birth date, admission and discharge dates, photographs, and health plan beneficiary number.
- Medical records, case histories, medical reports, images, raw test results, and medical dictations from healthcare facilities are used for Student learning activities. Although patient identification is removed, all healthcare information must be protected and treated as confidential.
- Students enrolled in School programs or courses and responsible faculty are given access to patient information. Students are exposed to PHI during their clinical rotations in healthcare facilities.
- Students and responsible employees or agents of School may be issued computer identifications (IDs) and passwords to access PHI.

**By initialing each statement, I agree to abide by the following statements:**

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<th>Initial</th>
<th>Statements</th>
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<td>1.</td>
<td>Any or all PHI, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.</td>
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<td>2.</td>
<td>Whether at the School or at a clinical site, Students are not to discuss PHI, in general or in detail, in public areas under any circumstances, including hallways, cafeterias, elevators, or any other area where unauthorized people or those who do not have a need-to-know may overhear.</td>
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<td>3.</td>
<td>Unauthorized removal of any part of original medical records is prohibited. Students and faculty may not release or display copies of PHI. Case presentation material will be used in accordance with healthcare facility policies. Copying of the original medical record is strictly prohibited.</td>
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<td>4.</td>
<td>Students and faculty shall not access data on patients for whom they have no responsibilities or a “need-to-know” the content of PHI concerning those patients.</td>
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<td>5.</td>
<td>A computer ID and password are assigned to individual Students and faculty. Students and faculty are responsible and accountable for all work done under the associated access.</td>
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<td>6.</td>
<td>Computer IDs or passwords may not be disclosed to anyone. Students and faculty are prohibited from attempting to learn or use another person’s computer ID or password.</td>
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<td>7.</td>
<td>Students and faculty agree to follow Hospital’s privacy and security policies.</td>
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<td>8.</td>
<td>Breach of patient confidentiality by disregarding the policies governing PHI is grounds for dismissal from the Hospital.</td>
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EXHIBIT B

PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY STATEMENT

• Need to Know Rule
  Before looking at a patient’s health information, ask the question “Do I need to know this to do my job?” If the answer is no, STOP! If the answer is yes, use it, but do not share it with anyone who does not need to know. Even though you may have access to the entire medical record or admitting/billing information, you may only legally look at the information you need to perform your job. The need to know rule applies to every individual in the organization; employees, contractors, students and volunteers. We are all responsible for following the Patient Privacy Policies and Principles.

• California Privacy Act
  A state law that works in concert with the federal HIPAA laws and is actually stricter than HIPAA laws. If you violate patient confidentiality and reveal patient information to someone without a “need to know” you can PERSONALLY be fined up to $250,000! California also requires a self-report by the Hospital to both the state and the patient (the federal laws do not) within five business days of when it becomes known (The California Privacy Laws SB541 & AB211 became effective 1/1/2009)

• I understand that Federal and State laws govern the confidentiality and security of PHI and that unauthorized disclosure of PHI is a violation of law and may result in civil and criminal penalties.

________________________________________
Signature of Participant

Print Name: ___________________________

Date: ________________________________
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HOSPITAL QUIZ

1. What is the BEST defense against fire?
   a. Prevention
   b. Fire extinguisher
   c. Smoke/fire doors
   d. Clearly marked exits

2. What protocol is used to respond to a fire?
   a. FIRE
   b. SAVE
   c. RACE

3. A yellow star on the doorframe means that the patient has been placed in restraints.
   a. True           b. False

4. Only nurses are required to observe patients who are in restraints or have yellow stars on their door.
   a. True           b. False

5. What is a best practice for protecting patients from electric shock and injury?
   a. Using damaged electric devices
   b. Removing the casing from electric devices
   c. Placing electric devices at a distance from patients
   d. Touching patients and electric devices at the same time

6. The Joint Commission expects hospitals to implement practices to prevent healthcare-associated infections (HAIs). What is one of these practices?
   a. Use of proper hand hygiene
   b. Use of iodine for disinfecting surgical tools
   c. Use of Contact Precautions for all admitted patients
   d. Use of Airborne Precautions for all admitted patients

7. A Fire is a:
   a. Code Blue
   b. Code Red
   c. Code Yellow
   d. Code Pink

8. The number you call for ALL Hospital Emergencies is 4911.
   a. True    b. False

9. If a patient visitor does not have an appropriate ID band/badge it is OK to use your badge to give them access to the floor they need.
   a. True    b. False

10. Patients, staff, and visitors can smoke anywhere on the hospital grounds.
    a. True    b. False
MEDICAL WASTE

Please write the letter from the container type column that indicates the proper disposal for each of the following items. Place answers on answer sheet.

**Container Type**

A. Blue Bag – Confidential Waste

B. Red Bag – Biohazardous Waste

C. Red Container – Sharps Waste

D. White Container with Purple Lid (Pharmaceutical Waste)

E. Clear Bags – Regular Trash

F. Black Container (Environmental Hazardous Waste)

**Discard Waste**

1. Paper towels
2. Empty bags labeled Biohazardous
3. Empty IV bag with block out label
4. Syringe with 3cc of blood in it (no needle)
5. Blood transfusion bag and tubing
6. Patient face sheet
7. Scratch paper with patient name on it
8. IV bag half-filled and cannot be emptied
9. Gauze with bloody spot the size of a quarter
10. Dressing that is dripping with blood
11. Suction tubing with body fluids still inside
12. Scalpels, trocars, guidewires
13. Syringe with less than 2ml of a controlled drug
14. Empty syringe with a needle on it
15. Empty urinals, bedpans, foley bag
INFANT SAFETY

Please choose the one best answer:

1. Which of the following describes the “typical” abductor?
   a. Female, under 30, friendly
   b. Male 30-50, dressed like a hospital employee
   c. Female, overweight, between 12 and 50 yrs. of age
   d. Young male between the 16 and 25

2. Where do most abductions occur?
   a. From home
   b. From hospital (mother’s room or nursery)
   c. Pediatric Unit
   d. Emergency Dept.

3. An abductor may pose as?
   a. MD, nurse, phlebotomist
   b. Volunteer or relative of a patient
   c. Hospital photographer
   d. All of the above

4. Which of the following should alert you?
   a. Employee face does not match ID picture on badge
   b. Infant being carried
   c. Inquiries as to hospital routines
   d. Non-employee in partial hospital dress
   e. All of the above

5. If a Code Pink or Code Purple is paged, staff/volunteers should:
   a. Monitor all exits and stairwells
   b. Tactfully stop and question any person(s) carrying a suspicious bundle or infant/child
   c. Check restrooms, storage rooms, or anywhere an abductor may hide
   d. All of the above

Answer the following A = True – or –B = False:

6. A diversion in another part of the hospital may be used to draw attention away and give an abductor time to take an infant/child and escape the premises.

7. Code Purple 2, 3rd floor indicates a 2 yr. old child is missing from the 3rd floor.

8. Abducted infants can be hidden in paper sacks, gym bags, or bundled in blankets.

9. If you are suspicious of anyone, get a detailed description of the person(s) or vehicle.

10. All maternal-child staff wear a special ID badge with a pink border framing the picture.
HIPAA – Health Insurance Portability and Accountability Act

Please answer the following A = True or B = False

1. HIPAA stands for Health Insurance Portability and Accountability Act.
2. Protected Health Information (PHI) includes all of the following: name, date of birth, admission date, types of meds/treatments, and reason for hospitalization, social security number, and health plan information.
3. Anyone caught violating patient privacy, can be fined up to $250,000 or go to jail for up to 10 years.
4. Any paper that has patient information on it can be placed in the regular trash, if you put it face down.
5. MARs and sign-in logs may be left open and seen by others, as long as the general public cannot view it.
6. A fax that has PHI in it, must have a cover sheet that contains a confidentiality notice.
7. If a fax with PHI is inadvertently sent to the wrong party, you must make reasonable efforts to obtain the copies or see that they are destroyed, as well as enter the information in a log.
8. Patients can give a 4-digit number to friends and family members, if they want their PHI shared.
9. Notice of Privacy must be provided to every patient on admission.
10. The RCH Facility Privacy Official is Janeille Kilgore.
11. We may disclose PHI medical information to caregivers taking care of the patient in the hospital or after discharge (ambulance transportation, hospice, home health, physicians) without the patient’s permission.
12. If a patient wants to remain confidential (opt out of the hospital directory), you must tell those inquiring that the patient has been admitted here, but give out no other information.
13. Employees who have access to the computer may view their own health information.
14. PHI may be sent over e-mail, because it is safer than regular mail or faxing.
15. If a patient believes his or her privacy rights have been violated, there is no recourse except to let the charge nurse know.
16. Patients have a right to request only to be contacted at work instead of their home and staff must comply.
17. PHI should never be discussed in general public areas such as elevators or the cafeteria.
18. Case managers or callers from other agencies must give at least three approved items of information to verify they are a legitimate requestor of information, such as patient name, the patient’s social security number, and patient’s date of birth.
19. Patient charts always need to be placed in a secured area.
20. Accounting of Disclosures means we have to keep a list of where a patient’s PHI has been disclosed for any reason other than for treatment, payment, or healthcare operations.
**COMPANY INFORMATION**

<table>
<thead>
<tr>
<th>Company name:</th>
<th>UCR School of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company address:</td>
<td>900 University Ave., Riverside, CA 92521</td>
</tr>
<tr>
<td>Business phone #:</td>
<td>951-827-1012</td>
</tr>
<tr>
<td>Business fax #:</td>
<td></td>
</tr>
<tr>
<td>Office Manager (full name):</td>
<td></td>
</tr>
<tr>
<td>Office Manager email:</td>
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<tr>
<td>Business need for access:</td>
<td></td>
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</table>

**PERSONAL INFORMATION**

<p>| Name: |</p>
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<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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</thead>
<tbody>
<tr>
<td>Home address:</td>
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<td>Date of birth:</td>
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<td>Personal cell #:</td>
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</tr>
<tr>
<td>Email address:</td>
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<tr>
<td>Network Login (3/4 ID)</td>
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**For Access please return back to your Facility Sponsor**

- Sunrise Hospital and Medical Center
- Mountainview Hospital
- Southern Hills Hospital and Medical Center
- Good Samaritan Hospital
- Regional Medical Center
- Los Robles Hospital and Medical Center
- West Hills Hospital and Medical Center
- Riverside Community Hospital

**Action:** □ New  □ Change  □ Delete  Effective Date: 

**System**

| Network access | MEDITECH | PACS Radiology |
| VDI / SRA | Horizon Patient Folder / HPF | PACS CV (Vericis/Merge) |
| Scheduling Express | PatientKeeper / PK | MUSE: Editor - Cardiology Imaging |
| Centricity Perinatal / CPN | Other: |

**Name of HCA IT&S staff member fulfilling access request:**